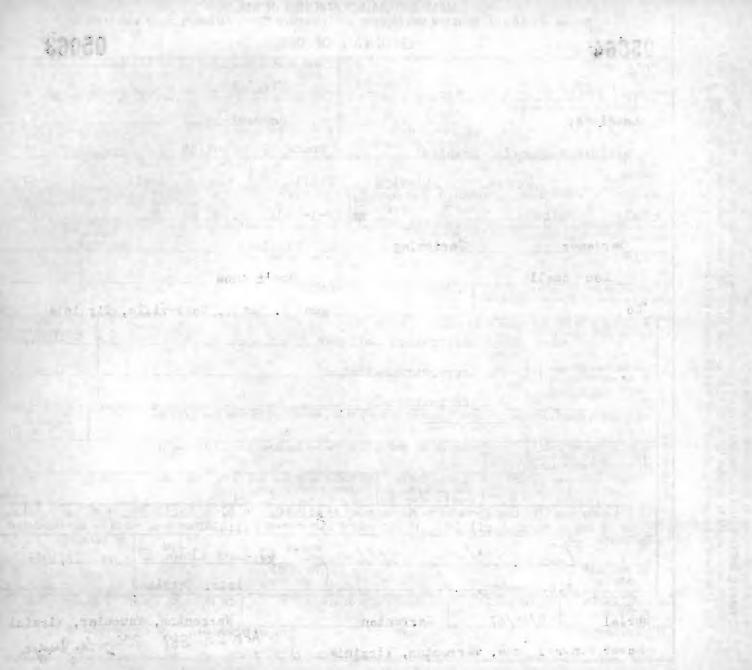
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #2 Film#G388 05063 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Maryland requires that the death certificate be executed within 24 hours after di di signed by the ottending physician and completely filled in by the buriol-transit permit. Then please remove carbon papers. Pages b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) papers. Pag hin 72 hours (write BURAL and give nearest town Charlotte Hall e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS within 72 YES NO F NAME OF First Middle 4. DATE Month Lost Year DECEASED erson DYT ra ce 19 (Type or print) DEATH everif F UNDER 24 HRS SEX 6, COLOR OR RACE AGE (In years 7. MARRIED NEVER MARRIED DATE OF BIRTH birthdoy) Months Days Hours and in ony WIDOWED DIVORCED 100. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired COUNTRY? INDUSTR) ENERAL SERVIC 14. MOTHER'S MAIDEN NAME FATHER'S NAME buriol, cremation, or removal, Address CIABRIOTTE HAR 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates at service MUSEULAN 18. CAUSE OF DEATH (Enter only one cause per ling for (o) (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH erebrovascul IMMEDIATE CAUSE (a O HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Page 4 may be retained by the hospital or ottending physicion. DUE TO Cardiovascular Conditions, if any, which gave rise to immediate cause (o), DUE TO stating the underlying cause os the this certificate hos been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 3 should be detached for use with the State Dept. of Health mellThu NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or lown) (County) (State) factory, street, office bldg., etc.) Haur a.m. Not While at work TO FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased from 1967 . ta. 12HDY and that death accurred at 705 M. from causes and an the date stated above saw the deceased alive an_ 22b. DATE SIGNED 22a, SIGNATURE M.D. DIRECTOR director, poge 3 should be filed a PHYS. 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23g. BURIAL CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (State) **REMOVAL** (Specify 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 196

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05064 deoth. The law requires that the death certificate be executed within 24 hours after death the funeral 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY o. STATE Charles MARYLAND Virginia attending physician ond completely filled in by the nearmit. Then please remove tarbon papers. Pages c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 15 write RURAL and give nearest town) hours La Plata,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) Nekesville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Route #2 Box189 Within. YES NO T Physicians Memorial Hospital 3. NAME OF Middle Lost 4 DATE Month Doy Year DECEASED event Clayton Beal1 April 26 19 67 (Type or print) Ernest DEATH 9. AGE (In years S. SEX IF UNDER 24 HRS IF UNDER 1 YEAR 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH lost birthdoy) Months Dovs Hours WIDOWED DIVORCED or removol, and in any Male White 8-1-1901 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)

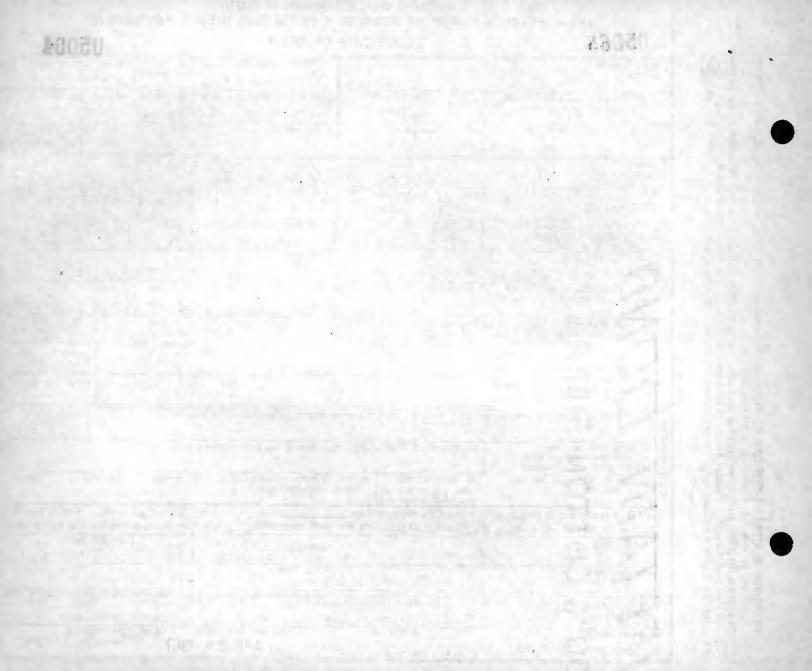
Gardener INDUSTRY COUNTRY? Gardening USA Virginia

14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Don tt. Know Lou Beall 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) No Eugene P. Beall. Nokesville. Virginia cremotion, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the buriof-tronsit p ONSET AND DEATH PART I, DEATH WAS CAUSED BY: Respiratory Collanse IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. 501X DUE TO Conditions, if ony, which gove Laryngotracheitis 4 days rise to immediate cause (a), DUE TO stoting the underlying couse as the O FUNERAL DIRECTOR: After this certificate hos been Bronchitis 3 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? use of Health NO Sc Į. 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER State Dept. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or lown) (County) (Stote) Hour o.m factory, street, office bldg., etc.) Not While 21. I certify that (1) (this haspital) attended the deceased fram April 18, 19, 67, to April 26, 19, 67, that (1) (we) last 19 67, and that death occurred at 11 . 43MP fram causes and on the date stated above saw the deceased alive an April 26 director, page 3 sho should be filed with 220. SIGNATURE 22b. DATE SIGNED **ATTENDING** XXIRECTOR April 27,1967 PHYS. ADDRESS 22c PHYSICIAN'S NAME (Type) La Plata, Maryland Wooddy 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 4/29/67 Warrenton Warrenton, Fauguier. 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Moser Funeral Home, Warrenton, Virginia VR A15 (4) 20 M 1/66 DATE



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05065 CERTIFICATE OF DEATH haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND C. LENGTH OF STAY IN 16 b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (if autside carparate limits, write RURAL and give negrest town) and give nearest town NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS papers YES PNO requires that the death certificate be executed within NAME OF Middle 4 DATE Day First Year DECEASED BROOK BANK OF DEATH the attending physician and campletel sit permit. Then please remave carbo ENCER (Type or print) 1 YEAR 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthday) Manths Days Haurs and in any WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) ER 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, ar remayal, NER WAS DECEASED EVER IN ILS ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, ar unknown) If If yes give war or dates of service VDE BROOKBAN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO burial Conditions, if ony, which gove Minona rise ta immediate cause (a) DUF TO stating the underlying couse Page 4 may be retained by the haspital or attending as the peen last. After this certificate has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? CERTIFICATION for use Health NO 20g. ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH af detached (IF EITHER, NOTIFY MEDICAL EXAMINER State Dept. 20e. PLACE OF INJURY (Home, farm, 201. (City or town) (Stote) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED (County) factory, street, office bldg., etc.) Hour a.m Not While of wark at wark 21. I certify that (1) (this haspital) attended the deceased fram 22 . 19617 . ta 19 66, and that death accurred at 9.133cm, from causes and an the date stated above O FUNERAL DIRECTOR: saw the deceased alive an 22a, SIGNATUR 22b_DATE.SIGNED M.D. DIRECTOR PHYS director, page shauld be filed 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (State) 23o. BURIAL, CREMATION (County) REMOVAL (Specify) LEMETERY 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b COUNTY Charles a. COUNTY o. STATE Maryland Charles with the State Department of MARYLAND b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) La Plata P.M3. Forest Park, Waldorf d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? with farm Physicians Menorial Hospital NO DO in pencil in Item 18. Give Pages This certificate should be executed within 24 haurs after death. 3. NAME OF First Middle Last 4. DATE Month Day Year DECEASED OF DEATH George Randall Clark April 6 67 (Type or print) ward "pending" in pencil in Item 18. Give the Chief Medical Examiner's Office alang 6. COLOR OR RACE B DATE OF BIRTH IF UNDER 24 HRS. S. SEX 9. AGE (In years IF UNDER 1 YEAR 7 MARRIED NEVER MARRIED last birthday) Months Hours 9/6/40 White Male WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even dretired ler COUNTRY? Government WASHINGTON, D.C. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME any event within 72 WAS DECEASED EVER IN U.S. ARMED FORCES? 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY - PLESPIRAIRE IMMEDIATE CAUSE (o) please execute the certificate, writing the ward DUF TO Conditions, if any, which gove rise to immediate cause (a). forwarded ta .⊑ DUE TO stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? remayal, yrad 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I ar Part II of item 1B.) 3 shauld Ö PRIMARY C or CONTRIBUTING E CAUSE OF DEATH crematian, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) State) Not While factory, street, affice bldg., etc.) may be retained for your FUNERAL DIRECTOR: Page of work 21. I certify that I took charge of the remains described above, held an Autopsy and in my opinion Inspection Inquiry Undetermined monner death resulted from: Notural couses Accident 1 Suicide Homicide CHIEF MEDICAL EXAMINER prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER Address (Street, city, tawn, or county) VR A 15ME (5) 6M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0506605067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence Before admission) · Charles Maryland b. COUNTY MARYLAND c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b Hughesville Md Hughesville Md 15-Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO X NAME OF Middle Last 4. DATE Year DECEASED (Type or print) Mary Beatrice Davis 4-1-67 19 DEATH JE UNDER 24 HRS 6. COLOR OR RACE AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED DATE OF BIRTH Months lost birthdoy) Doys Haurs Female Negro 9-7-1923 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT USA Brandy Wine Md 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME John Edward Brooks Alice Gray John F. Davis-Husband Hughesville Md. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, ar unknown) (If yes give war or dates af service No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY Tmmediate IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Indefinite Arteriosclerosis General Conditions, if ony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse Indefinite Aging process and obesity 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO. 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) foctory, street, affice bldg., etc.) Not While While of work at wark Inspection ... 21. I certify that I taok charge of the remains described above, held an Autopsy Inquiry and in my apinian deoth resulted from Natural causes X. Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER TACTUAL-22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER 4-1-1967 **EXAMINER'S** NAME (Typy ames E. Andrews MD Address (Street, city, town, or county Indian Head Md 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF April 4,1967 St. Thomas Church Cem. Brandywine, Pr. Geo. Md.

25a. REC'D BY REGISTRAR

25h REGISTRAR'S SIGNATURE

may be retained far your FUNERAL DIRECTOR: Page Health priar 50 VR A15ME (5) 6M 1/67

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This certificate shauld be executed within 24 hours after death

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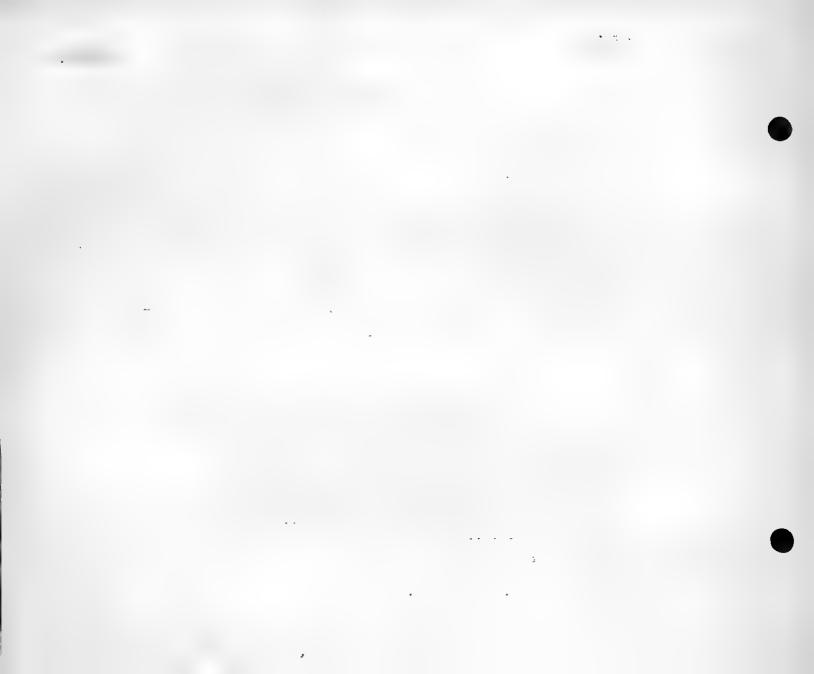
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 95068 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death). PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) isician and completely filled in by the funeral please remove carbon papers. Pages 1 and o. COUNTY o. STATE **b.** COUNTY Not popers. Pages 1 o Charles Charles MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (if autside carparate limits, c LENGTH OF STAY IN 16 Payoncans Potomac deights IS RESIDENCE ON A FARM? d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Physicans memorial Hospital YES NO X 3 NAME OF DECEASED Middie 4. DATE Day Year 5. DUDLES OF event, DEATH 196 (Type or print) AGE (In years S SEX DATE OF BIRTH 6 COLOR O MARRIED NEVER MARRIED lost birthdoy) Months Dovs WIDOWED DIVORCED January ond in our 10h KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT 100 JSUAL OCCUPATION (Give kind of work done **COUNTRY?** during most of working life, even if retired) INDUSTRY Virginia .cetired Gaverment Lynchburg 14. MOTHER'S MAIDEN NAM 13 FATHER'S NAME burial cremation or removal. Elizabeth Eacls Lee Dudley IS. WAS DECEASED EVER IN U.S. ARMED FORCES? izabeth Eck-」地質hter-Indian 16. SOCIAL SECURITY NO. signed by the attendir burial-transit permit. (Yes, no, or unknown) (If yes give war or dates of service) L. Dudley-Son Elmer None INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (p) DUE TO Conditions, if ony, which gove nse to immediate couse (a). DUE TO stating the underlying couse Page 4 may be retained by the hospital or ottending director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to O FUNERAL DIRECTOR: After this certificate hos been WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO 20o. ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INSURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg , etc.) Not While 19 , 19<u>6</u>/, that (I) (we) last 2]. I certify that (I) (this hospital) attended the deceased fram 4. and that death occurred at 2 P 300 M, from causes and an the date stated abave. sow the deceosed olive on. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING STAFF M.D. DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S La Plata . Laryland NAME (Type) Johnson 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o, BURIAL CREMATION 23b. DATE THEREOF (County) REMOVAL (Specify) Maryland Pomonkey_ John's Cemetery 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. PINERAL DIRECTOR VR A15 (4) 20 M 1/66 Funeral Home Inc la Plata



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence) PLACE OF DEATH COUNTY o STATE b COUNTY CHARLES Maryland Charles 0 MARYLAND c CITY OR TOWN (if outside corporate in its write RURAL and give nearest town) b CITY OR TOWN (If outside corporate im ts, c LENGTH OF STAY IN 1b write RURAL and give pearest_town) Hughesville d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RES DENCE ON A FARM? with form Physician Memorial Hospital Good Road NO P in Item 18. Give Pages NAME OF Farst M adle Last 4 DATE Month Year DECEASED OF DEATH **JAMES EDELEN** April 14. 19 67 (Type or print) Office along S SEX 6. COLOR OR RACE B DATE OF BIRTH 9 AGE (In years 7 MARR ED NEVER MARR ED 🔀 ost birthday) Months and in any event within 72 hours ofter death Negro WIDDWED DIVORCED Male 10o USLAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if ret red) **NDUSTRY** COUNTRY? 13 FATHER'S NAME This certificate should be executed within 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANI (Yes, no or unknown) (I yes a ve wor or dates of service) 18 CAUSE OF DEATH (Enter on y one couse per line for (o) (b) and (c)) NTERVAL BETWEEN PART I. DEATH WAS CAUSED BY **DNSET AND DEATH** Interstitial pneumonitis (SDII) IMMED ATE CAUSE (0). writing the word DUE TD Conditions, if any, which gove rise to immediate couse (a). DUE TO stating the underlying couse removol, WAS AUTOPS) PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION OF PART 1(o) CERTIFICATION YES X NO [200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) 3 should PRIMARY OF CONTRIBUTING CAUSE OF DEATH MEDICAL 20c TIME OF INJURY Month, Day, Year 20d N., RY OCCURRED 20e. PLACE OF INJURY (Home, form 20f (City or town) ((county) Hour o.m. foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Poge of work at work 21. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection Inquiry ond in my opinion Accident Notural couses X. Su cide . Homicide Undetermined monner be retoined CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASS STANT MED CAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** Charles S. Springate, M.D. April 14, 1967 Address (Street, city, town or county) NAME (Type) TO FUR BUR AL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) 24 FUNERAL DIRECTOR VR A15ME (5) 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05070 MEDICAL EXAMINER'S CERTIFICATE OF DEATH EALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Charles o STATE Maryland b. COUNTY the State Department of Charles MARYLAND b CITY OR TOWN (I outside corporate limits, write RURAL and give mearest town) c CITY OR TOWN (If outs de corporate amits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 La Plata Port Tobacco d NAME OF HOSPITAL OR INSTITUTION (f not in hospital, give street address) d. STREET ADDRESS IS RES DENCE ON A FARM? Office along with form Physicians Memorial Hospital □ NO IX in Item 18. Give Pages YES This certificate shauld be executed within 24 haurs after death 3 NAME OF First Lost 4 DATE Doy Year DECEASED OF DEATH 19 67 SHIRLEY FERRIS (Type or print) IF UNDER 24 HRS S SEX B DATE OF BRITE 6 COLOR OR RACE 7 MARRIED AGE (In years NEVER MARRIED lost birthdoy) Months ношт July 12,1920 White WIDOWED DIVORCED Female 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12 CITEZEN OF WHAT during most of working life, even if retired) Winterset, Iowa the Chief Medical Examiner's 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME in pencil and in any event within 72 hours Walter Cord Bessie Davis IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address pending" i (Yes, np. or unknown) (If yes give wor or dotes of service) Mr. William J. Ferris-Port Tobacco, No. Unkown INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) ONSET AND DEATH PART I DEATH WAS CAUSED BY Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (o) should be farwarded to the Ch DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying couse last be used remaval, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM WAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPSY PERFORMED? CERTIF CAT ON please execute the certificate, YES 😿 NO 200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) 3 should cremation, ar **CAUSE OF DEATH** MEDICAL 20e. PLACE OF INJURY (Home, form (City or town) 20c. TIME OF JULY Month, Doy, Year 20d NJURY OCCURRED (County) Hour om. factory, street, office bldg., etc.) ot work 5 may be retained in y
TO FUNERAL DIRECTOR: P
Health priar to burial, a 21. I certify that I taak charge of the remains described above, held an Autapsy X. Inspection . Inguiry [7], and in my opinion Natural causes X. Su cide . Ham cide death resulted fram Accident Undetermined manner the funeral directar CHIEF MEDICAL EXAMINER 22 DATE SIGNED ASS STANT MED CAL EXAM NER X 4-3-67 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) U. SPITZ. 23c. NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d. LOCATION (City or Town) (County) 230 BUR AL, CREMATION, BREMOVAL (Specify) 4/6/1967 Waldorf, Laryland Trinity Lemorial Gardens 24 FUNERAL DIRECTOR VR A15ME (5) 6M 1/67 runeral Home, Inc .- La lata, Ld. Arehart



FOR HEALT

In s certificate should be executed within 24 hours ofter death. If any delay is

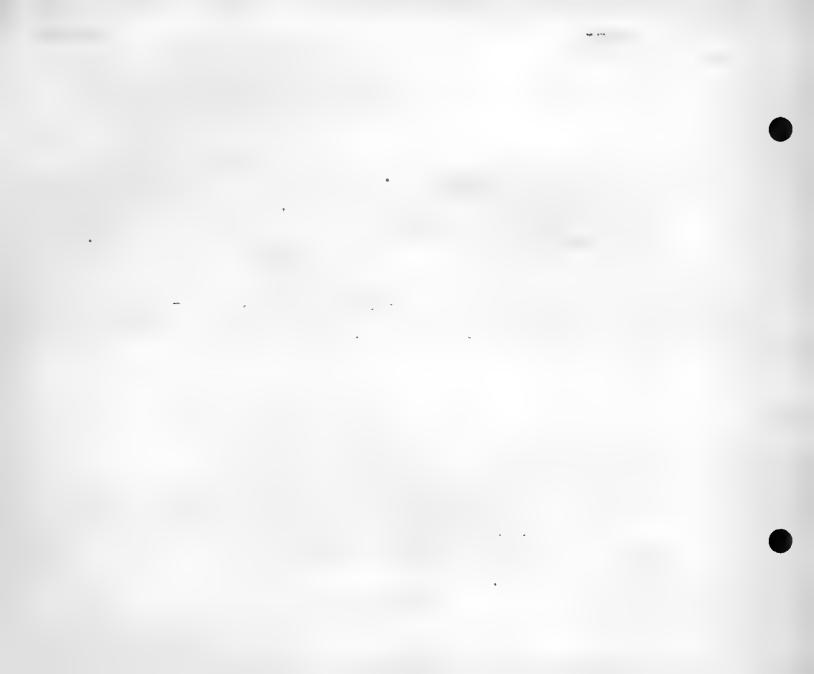
TO DEPUTY MEDICAL EXAMINER:

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

nknyn

OR STATE		nonti	MEDICAL EXAMINER'S	CERTIFICATE O	F DEATH	00010
ALTH DEPT.		PLACE OF DEATH O COUNTY Charles	MARYLAND	CTATE .	Where deceosed lived, if institut 71and	ion [.] Residence before odmission) TY Charles
PM3. Page artment of		b (ITY OR TOWN (.f outside carporate limi write RURAL and give nearest tawn) Wayside	its, C LENGTH OF STAY IN 1b	C CITY OR TOWN (IF ou	itside corporote limits, wr'te RUF Bide	RAL and give nearest town)
ry, please execute the certificate, writing the ward "pending" in pencl in Item 18. Give Pages 1, 2 eral director. Page 4 should be forwarded to the Chief Medical Examiners Office along with form be retained for your files. RAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages land? with the State Departor to burial, cremation, or removal, and in any event within 72 hours after death.		d NAME OF HOSPITAL DR INSTITUTION (I n	not in haspita, give street address)	d, STREET ADDRESS		e S RESIDENCE ON A FARM? YEX NO
	3 NAME OF POST AMES ALLIAM W.			lost GREEN	4 DATE Mont OF DEATH Apr	il 12 19 67
	_	Male Negro	7 MARRIED NEVER MARRIED WIDDWED DIVORCED		1900 9. AGE (In years lost b rthdoy) 66 yrs.	Months Doys Hours Min.
	dur	USUAL OCCLIPATION (Give kind of work done ing most of work done	e 106 KIND OF BUSINESS OR	IN BRITHPLACE (Stote	, Maryland	12 CITIZEN OF WHAT COPNTRY? A.
		FATHERS NAME Ernest Gree			za Donley	
	\$5 (Ye	WAS DECEASED EVER NUS ARMED FORCES?	s of serv (e) 16 SOCIAL SECURITY NO 17 22	James R		7613 Canyon 5
		Conditions, if ony, which gove	ouse per line for {a}, {b} and {c}} E {o} Hypertensive Cardi E TO (b) II TO {c}	ovascular D		SASEINT NURVAL RETWEEN ONSET AND DEATH
	MEDICAL CERTIF CAT ON	PART I OTHER SIGN F CANT (DINDITIONS	CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE COI	NDITION GIVEN IN PART I(o)	19 WAS AUTOPSY PERFORMED? YES K NO
		200. EXTERNAL CAUSE WAS PRIMARY Tor CONTRIBUTING CAUSE OF DEATH	20b DESCRIBE HOW NJURY OCCURRED		·	
		20c, TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19	While - Not While - foo	ICE OF INJURY (Home forn tory, street, office bldg., etc.		(County) (State)
		death resulted from. Natur	der leing	cide [], Hamicide CHIEF MEDICAL M.D ASSISTANT MED DEPUTY MEDICA	Undetermined m	oiry, and in my apiniar anner
the fun 5 may 70 FUNE	230	BURAL (REMATION, 23b DATE-TH	HEN 967 236 NAME OF CEMETERY DR HOLY Ghost	CREMATORY Cemetery	23d LOCATION (City or To Issue,	wn) (County) (State) Laryland
VR A 15ME (5)	24	FUNERAL DIRECTOR Arehart "uneral	Home, IncLa Plat	ca , r.d DAN R		EGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05072 MEDICAL EXAMINER'S CERTIFICATE OF DEATH I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a STATE b COUNTY Charles MARYLAND b CITY OR TOWN (If autside corporate mits, C LENGTH OF STAY IN 16 c CITY OR TOWN (if autside carparate +m.ts, write RURAL and give negrest town) PM3. write RURAL and give nearest town)
La Plata haurs after Ashland d NAME OF HOSPITAL OR INSTITUT ON (If not in haspital, give street address) d STREET ADDRESS S RESIDENCE ON A FARMA Physicians NO [Memorial Union Street 3 NAME OF DATE Day DECEASED within DEATH S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED F UNDER 1 YEAR My (day) Months WIDOWED DIVORCED Office 귳 10a USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CT ZEN OF WHAT during most of working life, even if retired) INDLSTRY COUNTRY? 200 Ret State Senator
13 FATHERS NAME pages in any Politics St. Paul Winn
M. MOTHER'S MAIDEN NAME IIS A Ingel Olson Hanna C. Anderson gud VERNOWS CONN. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 18 SOCIAL SECUR TY NO 17 INFORMANT (Yes, no, or unknown) (If yes give war ar dates of service) remayal. Victor V. Magnuson, Rosewood Drive, 18 CAUSE OF DEATH (Enter only one cause per INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ND. IMMEDIATE CAUSE (a) certificate shauld s a burial-tro e, writing the ward farwarded to the Cl DHE TO Conditions, flany which gave rise to immediate couse (a), DUF TO stoting the underlying couse used as burial, c PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT SOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? YES NO. 20g. EXTERNAL CAUSE WAS 20b DESPINE HOW INJURY OCCURRED LEnter notife of injury in Port I or Part II of item 18) 3 shauld PRIMARY Dor CONTRIBUTING E CAUSE OF DEATH 20e. PLACE OF INJURY (Home, form)
factory, street, off co bidg, etc.) 20c. TIME OF INJURY Month, Day, Year (State) (Count Nat While at work 21. I certify that I took chargesof the remains described above, held on Autopsy [7] Inspection ond in my opinion death resulted from National causes Accident -Suicide Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** TO FUNE Health NAME (Type) Andress (Street, aty, town, or county) 230 BURIAL, CREMATION, 23d LOCATION (City or Town) Burial (Specify) Wildwood Cemeter Ashland 24. FUNERAL DIRECTOR 2So RECD BY REGISTRAR VR A15ME (5) DATEAPR Arehart Funeral Home Inc. La Plata Ad. 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 18 05073 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o COUNTY o STATE b (OUNTY CHARLES 0 MARYLAND State Deportment b (TY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. C.TY OR TOWN (If outside corporate limits, write RJRAL and give nearest town). ASHLAND LAPLATA d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS e IS RESIDENCI Office along with farm ON A FARM? 59 North Union Street LA PLATA Hospital NO PC be executed within 24 hours after death 3 NAME OF OLSON . First Middie 4. DATE Month Year DECEASED 0F in pencl in Item 18. Give OLSEN Victor Ε. April 19 67 DEATH 6. COLOR OR RACE B DATE OF BIRTH 9 SACE (In years IF UNDER I YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED Months Dovs WIDOWED DIVORCED 8 ond in ony event within 72 hours ofter death lond ? Male White 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR B.RTHP. ACE (State or foreign country) 12 CT ZEN OF WHAT during most of working life, even it refired)

Security Officer-State of Mass. **COUNTRY?** Walstalchyslet 14 MOTHER'S MAIDEN NAME writing the word "pending" in penc! in rwarded to the Chief Medical Exominer's HS A permit. File pages 13 FATHER'S NAME Ingel Olson Hannah C. Anderson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Braintree" Mass. (Yes, no, or unknown) (If yes give wor or dotes of service) Beatrice Baker. 224 Common St. Yes 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (t).)
PART I DEATH WAS CAUSED BY
Fracture INTERVAL BETWEEN ONSET AND DEATH Fracture of thoracic vertebral column MMEDIATE CAUSE (a) This certificate should with laceration of two intercostal arteries DUE TO Conditions, if any, which gave and right hemothorax rise to immediate couse (a). farwarded to DUE TO stating the underlying couse 0 removal, PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPS PERFORMED? CERTIFICATION YES T NO should be 200 EXTERNAL CAUSE WAS PRIMARY OF OF CONTRIBUTING A 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18.) 3 should CAUSE OF DEATH Driver in auto-auto collision 20c TIME OF INJURY Manth, Doy, Year 20e PLACE OF NJURY (Morne, form 20f (City or town) (Caunty) While of work of work foctory, street, office bldg., etc.)
Highway FUNERAL DIRECTOR: Poge 11-9-6719 La Plata, Charles Co., Md. Poge 4 21. I certify that I took charge of the remains described above, held an Autopsy 12. Inspection , Inquiry , and 'n my apinian Acc dent X Suicide , Hamicide Undetermined manner death resulted from. Natural causes CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED 5 mc. TO FUNERA. Health prior 7 ASSISTANT MED CAL EXAMINER SIGNATURE DEPUTY MED CAL EXAM NER Charles S. Springate, M.D. April 10, 1967 EXAMINER'S NAME (Type) Address (Street, city, town or county) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 230 BJRIAL CREMATION (County) (Stote) BUTTEL Specify) Wieldwood Cemetery Ashland, Mass. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15ME (5) 6M 1/67



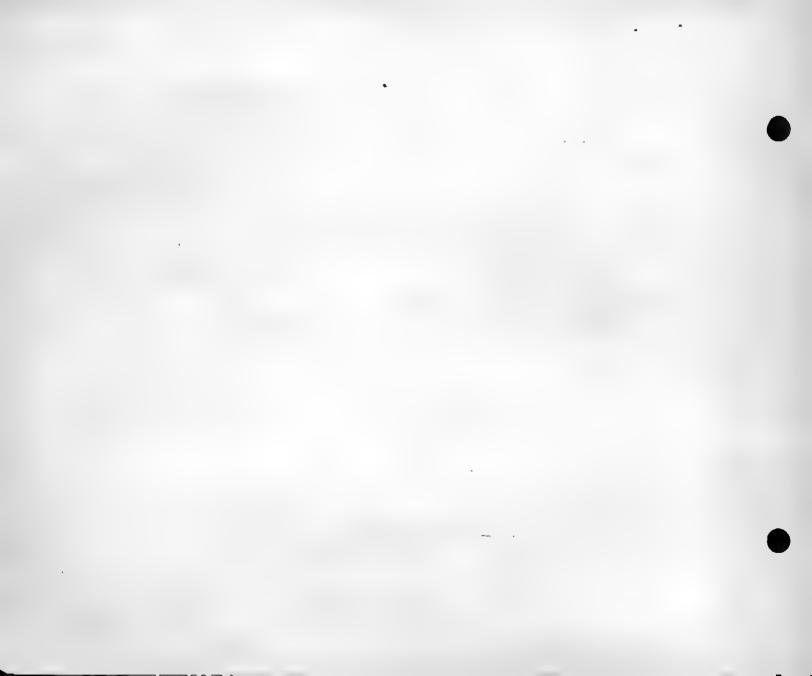
ON OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE THAT MARYLAND STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH funeral and 2 death. death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY after MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits. c. LENCTH OF STAY IN 1b write RUBAL and give nearest town) DORF NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS No 🔽 YES with completely bon NAME OF Middle Month Day DATE Year DECEASED OF event, DEATH (Type or print) ACE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS and con 6. COLOR OR RACE BIRTH DATE OF **NEVER MARRIED** 7. MARRIED last birthday) Months Days Hours ank WIDOWED 🔀 DIVORCED 10a. USUAL OCCUPATION (Cive kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT nas been signed by the attending physician as the burial-transit permit. Then please prior to burial, cremation, or removal, and in during most of working life, even if retired) COUNTRY? 657 certificate 13. FATHER'S NAME MOTHER'S MAIDEN NAME WENS HENR 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address death (Yes, no, or unkown) (If yes give war or dates of service) INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: or attending physician. IMMEDIATE CAUSE (a) DUE TO Cenditions, If any, which (b) gave rise to immediate **DUE TO** cause (a), stating underlying cause last. (c) CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) for use Health as PERFORMED? NO X YES the hospital 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING [this certi etached 1 Dept. of OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 19 retained o that (I) (we) last 21. I certify that (I) (this hespital) attended the deceased from DIRECTOR: age 3 should ifed with the saw the deceased alive and that death occurred at M, from the causes and on the date stated above. 22b DATE SIGNED 22a. SICNATURE page ATTENDING MFO. STAFF PHYS DIRECTOR PHYS. M.D. Page 4 may O HOSPITAL FUNERAL TO FUNCTION, DE ADDRESS 22c. PHYSICIAN'S NAME (Type) CEMETERY OR CREMATORY NAME OF LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. 230. (State) REMOVAL (Specify) ADDRESS REC'D BY RECISTRAR 25b. REGISTRAR'S SIGNATURE **FUNERAL DIRECTOR** VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before odmission) a. COUNTY o. STATE b. COUNTY Maryland Charles Charles ofter deoth. MARYLAND b CITY OR TOWN (f outside carparate simils. c LENGTH OF STAY IN 16 c CTY OR TOWN (If autside corparate limits, write RURAL and give nearest town) write RURAL and give negrest town) Sel Alton (Rural Rurall Bel Alton d NAME OF HOSPITAL OR INSTITUTION (if not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A EARM? hours Office olong with form YES ANO in Item 18 Give Pages 24 hours after deoth. 3 NAME OF First_ Middle Last 4 DATE Manth With the Swithing DECEASED (Type or print) DEATH S SEX 6. COLOR OR RACE NEVER MARRIED 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR 7. MARRIED 201 birthday) June 17,1942 Manths WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 10a LSUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT during most of working life, eyen if retired) Marming COUNTERS H Charles County , I.d. pages I in ony 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within pencil nattie Briscoe John ... Smallwood ond 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT .6 SOCIAL SECURITY NO Address or removal. (Yes, pa, ar unknown) (If yes give wor or dates of service) 220-38-1627 John w. Smallwood -Bel Alton, Ind. 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) France) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET (AND DEA IMMEDIATE CAUSE (a) This certificate should please execute the certificate, writing the word buriol, cremotion, DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOP: PERFORMED? NO designoted agent, prior to 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of njury in Part I or Part II of Item 18) PRIMARY OF CONTRIBUTING CAUSE OF DEATH 20c TIME OF INJURY Month Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or fown) (County) (State) 5 may be retained for your fi TO FUNERAL DIRECTOR: Page 3 Health or its designated agen Наш а т. factory, street, office bldg , etc) Not While at work at wark 21. I certify that I book charge of the remains described above, held on Autapsy. Inspection [X]. Inquiry XX and in my opinion the funeral director. death resulted fram. Accident . Suicide Homicide Undetermined manner Matural causes CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEBUTY MEDICAL EXAM NER EXAMINER'S Edelen La Plata . P. D. Address (Street, city, town, or county) NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town) 230 BUR AL, CREMAT ON, Issue , Laryland Holy Ghost Cemetery ADDRESS 25b REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 250 REC D BY REGISTRAR VR A15ME (5) Arehart Funeral Home Inc. -La Plata, Ad Mary



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEF 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) COUNTY o. STATE Page 2 Charles MARYLAND Marvland Charles delay b (TY OR TOWN (If autside carparate mits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If guts de carparate en ls. write RURAL and give negrest town) pup write RURAL and give nearest town)
La Plata Hilltop State Depart d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE alang with farm ON A FARMY Physicians Memorial Hospital YES IN NO in pencil in Item 18. Give Pages be executed within 24 haurs after death NAME OF First M.ddte Last 4 DATE Manth Day DECEASED OF CALVIN WARREN April 67 10 (Type or print) DEATH S SEX IF UNDER 24 HRS 6 COLOR OR RACE 9 AGE (In years IF UNDER 1 YEAR DATE OF BIRTH 7. MARRIED NEVER MARRIED × × last birthday)" Months Male Negro WIDOWED DIVORCED Off.ce 10a USJAL OCCUPATION (Give kind at wark done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during mast of warking the, even , retired) INDUSTRY COUNTRY 2 hours after pending" in pencil in ef Medical Examiner's bages 13. FATHER'S NAME NKOW WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war ar dates of service) event within INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) writing the ward "per Jrial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH Interstitial Pneumonitis. (SDII) IMMEDIATE CAUSE (a) This certificate shauld DUE TO In any Conditions, if any, which gove (b) nse ta immediate cause (a), DUE TO stating the underlying cause farwarded lost OS (c) WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) remayal, CERTIFICATION YES 🔀 NO the certificate, De 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I at Part II at item 1B.) 3 shauld Ö PRIMARY To an CONTRIBUTING TO CAUSE OF DEATH crematian, MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year Nat While Hour a.m. foctory, street, office bldg. etc.) may be retained for your FUNERAL DIRECTOR: Page at work at wark 21. I certify that I took charge of the remains described above, held on Autopsy [X]. Ingu ry Inspection and in my opinion death resulted from Homicide Noturol couses X Accident Suicide Undetermined monner CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE M.D O DEPUTY 4/9/67 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Charles S. Petty TO FUNE Hea¹th NAME (Type) Address (Street, city, town, or county) 230 BURIAL TREMATION NAME OF CEMETERY OR CREMATORY (State) 23d LOCATION (City or Town) REMOVAL (Specify) 24 FUNERAL DIRECTOR VR A 15ME (5) 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05076 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence b Charles a. STATE b. COUNTY of death. Washington D.C. MARYLAND parfment b. CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) write RURAL and give nearest town) after Indian Head Md d. STREET ADDRESS 0 29 Hanna Place.S.E e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Mours YES NO IX. R ate Carlisle hours after death. 3. NAME OF Lost Month Year Carolise DECEASED Williams. Jr. 4-10-67 Item 18. Give 19 (Type or print) within DEATH Office alang NEVER MARRIED IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED birthdoy) Male Months 8 Dovs Haurs Negro 9-1-1957 DIVORCED N event 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work dane BIRTHPLACE (State or foreign country) during most of working life, even if retired) Washington D.C. COUNTRY? MOME dny None USA Examiner's 13. FATHER'S NAME pencil 14. MOTHER'S MAIDEN NAME be executed within = File pup WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT remayal. (Yes, no, or unknown) (If yes give wor or dotes of service) Sheriff; s Office LaPlata Md None No None. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) Fatal Submersion cremation, ar ward This certificate should DUE TO Conditions, if any, which gave rise to immediate cause (o), DUE TO stoting the underlying couse burial, PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY PERFORMED? Was fishing from a boat of Marshall Md. 3-12 67 Disappeared YES NO T 2Do. EXTERNAL CAUSE WAS pridr 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) should PRIMARY OF CONTRIBUTING shauld CAUSE OF DEATH agent, 2De. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED (City or town) (County) (Stote) foctory, street, office bldg., etc.) Hour o.m. Not While of work at wark lease execute its designated 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection X and in my apinion Inquiry | x FUNERAL DIRECTOR: death resulted from: Natural causes" Accident x Suicide Hamicide Undetermined manner the funeral director. may be retained CHIEF MEDICAL EXAMINER ACTUAL SIGNATURE 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER 4-10-67 TO DEPUTY 0 DEPUTY MEDICAL EXAMINER EXAMINER'S Indian Head Md James E. Andrews Address (Street, city, town, or county) MD CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 0 4-15-REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR ATSME 6M 1/66

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05077 05077 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY delay is and 3 to Page MARYLAND e Department C LENGTH OF STAY IN 1h c CITY OR TOWN b. CITY OR TOWN (If outside corporate limits. outside corporate limits, write RURAL and give nearest town) PM3. write RURAL and give nearest town alden d NAME OF HOSPITAL OR INSTITUTION (If note hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS pencil in Item 18. Give Pages 1, Office olang with form NO IX YES This certificate should be executed within 24 hours after death. NAME OF Middle 4. DATE Month Year Lost Dov DECEASED OF DEATH Type or print IF UNDER I YEAR S. SEX OLOR OR RAC 7. MARRIED NEVER MARRIED B DATE OF BIRTH AGE (In years lost birthdoy) Months Dovs Hours hours after death WIDOWED DIVORCED lond2 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working lite, even if retired) ING the Chief Medical Examiner's pages 13. FATHER'S NAME 14. FILE IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) pending ond in ony event within INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) burial-transit SMISET AND PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' writing the word DUE TO Conditions, if any, which gove 10 rise to immediate couse (a). DUE TO stating the underlying couse 0 forwarded 90 lost nsed removol, 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) certificate, NO 4 YES pe 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 3 should PRIMARY I or CONTRIBUTING [TO should EXAMINER: CAUSE OF DEATH cremation, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (State) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (County) Hour am foctory, street, office bldg., etc.) Not While FUNERAL DIRECTOR: Poge of work please execute of work 21. I certify that I took charge of the remains described abave, held an Autopsy [Inspection Inquiry and in my opinion Notural couses deoth resulted from: Accident Suicide Homicide Undetermined monner the funeral director retained CHIEF MEDICAL EXAMINER 0 ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE Heolth prior TO DEPUTY necessary, pe DEPUTY MEDICAL EXAMINER EXAMINER'S Address (Street, city, town, or county) NAME (Type) 23o. BURIAL CREMATION (County) 0 29-24. FUNERAL DIRECTOR 250. REC'D BY REGISTRAR 25b REGISTRAD'S SIGNATI VR A15ME (5) TTUNERAL 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

